

DEPARTMENT OF HEALTH SERVICES

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P.O. BOX 942732
SACRAMENTO, CA 94234-7320



(916) 657-2941

December 20, 1994

TO: All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

Letter No.: 94-99

REQUIRED APPOINTMENT OF REPRESENTATIVE FORM FOR AUTHORIZED REPRESENTATIVES-
COMPETENT INDIVIDUALS

Ref.: E-Mail No. 94004, 94031, and 94047; All County Welfare Directors Letter (ACWDL)
No. 94-70, 94-62, 94-42, 93-84, 91-98, and 86-37

This ACWDL supersedes E-Mail Nos. 94004, 94031, 94047, and information concerning Authorized Representatives in ACWDL No. 91-98.

The enclosed **Appointment of Representative** form will be required for all Medi-Cal cases where an "authorized representative" (AR) is designated to assist the client in the Medi-Cal application or redetermination process. This form is to be used only for competent applicants/beneficiaries. Persons determined to be "incompetent" are unable to designate another as their AR. Issues involving incompetent individuals will be addressed in a future ACWDL.

It should be noted that this form is very limited in scope. It should be viewed as an agreement between the applicant/beneficiary, the individual designated to assist the applicant/beneficiary, and the county welfare department (CWD). If the applicant/beneficiary wishes to delegate additional authority to the AR to act in a legal capacity, the applicant/beneficiary will need to make additional specific arrangements with the AR. The form does not permit the AR on-going case management ability, access to other programs, or access to information without the clients specific knowledge and consent.

This letter is to clarify the use of the **Appointment of Representative** form as well as Department of Health Services (DHS) policy in regard to the AR.

Counties are to implement usage of this form within 60 days of the date of this letter. A camera ready copy of the form is enclosed to enable the counties to implement pending the form's availability in the warehouse. The form will be printed on NCR paper. Counties may order the **Appointment of Representative** form (MC 306) on or after December 16, 1994 through the normal process. A Spanish version is also enclosed.

BACKGROUND: Need For A Standardized Form

This required form is the result of an expressed need for a standard authorization form. Currently, various AR groups are using authorization forms which give them powers not founded on regulation. Each of these forms have been found to be overbroad in their terms and are not consistent with established Medi-Cal policy or Social Security regulations. Because of the difficulties that CWDs are having in an attempt to comply with regulation and, at the same time, accommodate the authorizations, it has been determined that a standard, required form must be implemented.

Input on the form, which this ACWDL addresses, is the product of several months of review by the County Welfare Directors Association (CWDA) Forms Committee, the CWDA Medical Care regional representatives, the Disability Evaluations Division (DED) and several counties as well as various AR groups such as Hayt, Hayt & Landau and Syndicated Office Systems. Questions and comments resulting from those reviews have been incorporated in this letter.

Question 1: Specifically what is the purpose of this form?

Answer 1: The Appointment of Representative form is to provide a standardized vehicle for an applicant/beneficiary to designate an individual to assist him/her in the Medi-Cal application or redetermination process. The form details:

1. the actions that the AR is able to take on behalf of the applicant/beneficiary based on current Medi-Cal regulations;
2. the applicant/beneficiary and ARs responsibilities; and
3. the rights of the applicant/beneficiary in regard to appointing and revoking the designation.

As stated on page one of this letter the form is an agreement and acknowledgement of all parties involved and authorizes the county to work with the AR.

Question 2: Our county refers to anyone acting on the behalf of an applicant/beneficiary as a "key person". Is this form to be used for authorization of "key persons"?

Answer 2: No. The term "key person" is not a Medi-Cal term. Some counties refer to "key persons" as family members or friends who assume case management responsibility for physically incapacitated individuals. The policy and regulatory requirements have not been changed for mentally incompetent individuals. While anyone may complete and file the initial application for Medi-Cal, an incompetent individual must have a spouse, conservator, guardian, or executor to act on their behalf. If none of these exist, then the county must determine the need for protective services and ultimately can act on behalf of the applicant/beneficiary as a public agency. If no protective service is needed, another relative or a friend with personal knowledge of the circumstances of the applicant/beneficiary may act for them. This form is not intended to designate a "key person" for incompetent persons.

Question 3: What do we do if someone is illiterate or physically unable to fill out the AR form?

Answer 3: The same procedures now used by the county to process applications for persons who cannot read or write should be followed. The eligibility worker (EW) must carefully go over the paper work, including the Appointment of Representative form, so that the applicant/beneficiary fully understands the content. The client may sign by an "X" with a witness signing and dating next to the "X".

Question 4: What do we do if the applicant/beneficiary or the AR refuses to sign the form?

Answer 4: If the person designated as the AR or the applicant/beneficiary refuses to sign the Appointment of Representative form, then the individual will not be recognized as the AR. The form will not be valid.

All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons
Page 3

Question 5: Is the current DHS 7068 (Public Guardian/Conservator or Applicant/Beneficiary Representative Responsibilities) now obsolete or replaced by this form?

Answer 5: No. The DHS 7068 is a form to be given to the public guardian, conservator, or representative acting on behalf of incompetent persons. The Appointment of Representative form is not to be used for incompetent persons. Counties should be aware that the DHS 7068 has been revised and retitled Responsibilities of Public Guardians/Conservators or Applicant/Beneficiary Representatives.

Question 6: Does this form take the place of the MC 219 in regard to reporting responsibilities, penalties for fraud, withholding information, and consequences for deliberate falsification of material facts?

Answer 6: No. This form does not take the place of the MC 219 which addresses all of these issues. The applicant/beneficiary is still the responsible person and the responsibility to provide truthful and accurate information rests with the applicant/beneficiary. The AR is only permitted to assist the applicant/beneficiary in the interview process, to submit verifications and to represent the beneficiary/applicant in the hearing process. No other authority is intended or granted with this form. Additionally, the applicant/beneficiary is given to understand that if the AR fails to perform as the applicant/beneficiary intends and the application is denied or discontinued due to that failure, the applicant/beneficiary must accept the consequences of the AR's actions or inactions. Again the purpose of the form is limited in scope and is intended only to act as the agreement for the AR to assist the applicant/beneficiary.

Question 7: Current regulations allow the applicant to appoint legal aid or an organization to be his/her AR. Does this form change this regulation?

Answer 7: No, this form does not alter current regulations. The regulations referred to are in the Department of Social Services' Manual of Policies and Procedures and are concerned with the applicants right to representation in the hearing process. However, DHS has reexamined these regulations and it is thought that presently an organization, law firm, or group MAY be the selected AR. However, an individual from that law firm, group, or organization will still have to be designated on the form so that the client and the county will know which person from the law firm, organization, or group is the person empowered to be the contact person. If the designated individual no longer works in that capacity then a new form will have to be completed to designate another individual. Since this form is valid only through the application/redetermination stage and through the conclusion of the hearing process, it is unlikely that requests for multiple ARs will be made.

Question 8: Can the client have more than one AR?

Answer 8: Yes. The client may have any number of persons acting as his/her AR. However, each individual must be designated on a separate Appointment of Representative form and the applicant/beneficiary and the AR must sign each form.

Question 9: The form states that the authorization expires upon a final eligibility determination. Can the AR continue to act on the applicants behalf until the fair hearing process is completed?

Answer 9: Yes. The AR may continue to act on the applicant/beneficiary's behalf only to the extent that the AR may continue to assist the applicant/beneficiary through the conclusion of the hearing process. The CWD should be lenient in allowing family members of applicants/beneficiaries to assist them after the eligibility determination has been made. This form is used primarily for nonfamily individuals who may have no interest in the applicant/beneficiary other than the approval of Medi-Cal benefits. The distinction is important. DHS is interested in the confidentiality of the client's records and wants to ensure that only pertinent information is obtained/distributed for a client and with the client's specific knowledge and consent. The CWD should verify as much as possible that the client actually wants a family member to work on his/her behalf and to identify the family member that may be assisting the client. While DHS is neutral in its stand in regard to an applicant/beneficiary desiring to pay an individual to assist them with their Medi-Cal, the client should be made aware that the CWD is mandated to assist them in the establishment of eligibility without charge (California Code of Regulations, Title 22, Section 50101(7)).

Question 10: Why does the form limit the period of time that an AR can act?

Answer 10: If a favorable determination of eligibility or continued eligibility is made, it is concluded that the need for the AR's services has ended. There would be no further point for an AR to act on the client's behalf. (Again, this pertains to competent individuals). If the decision is not favorable, then the AR is permitted to continue to assist the client until the conclusion of the hearing process.

Question 11: Many AR forms now in use have a "built in" conflict of interest waiver for AR's that not only act for the applicant but, at the same time, handle medical provider claims. Why doesn't the Appointment of Representative form have this conflict of interest statement?

Answer 11: Although the federal Medicaid regulations do not prohibit an AR from acting as both the applicants' and providers' representative, it is DHS' view that such a waiver contained in the AR form would not necessarily constitute awareness on the part of the applicant. A separate conflict of interest waiver form should be completed in those cases of double representation. It is the responsibility of the AR to obtain and prepare such a waiver.

Question 12: After the AR and applicant/beneficiary complete the form, can the AR obtain information directly from other sources, such as bank balances, income, etc., with this form?

Answer 12: No. As stated previously, this form is not an all inclusive release of information form. It is meant only to allow the AR to work with the client and the CWD, to assist the client in obtaining benefits or in completing the yearly redetermination. No other powers or authorities are given. The CWD has release of information forms which can be completed and sent by the CWD to obtain any information that the applicant/beneficiary is having difficulty obtaining. Any other information, such as medical records, must be obtained using specific release of information forms which should be filed with the agencies which have the requested information. It is the responsibility of the CWD to provide assistance to the applicant/beneficiary to obtain any verification needed for the determination of eligibility. The CWD is not to deny benefits to anyone who is not able to provide verification without first assisting the applicant in obtaining the information. Availability of resources, etc., must be

Question 13: Is the AR entitled to receive the recipients Medi-Cal or Benefits Identification Card (BIC) once he/she has been designated as the AR?

Answer 13: Many forms used by organizations acting as AR's state that the AR has the right to obtain the Medi-Cal card, medical records, etc., from the CWD and other facilities. This is not correct. The Medi-Cal card, and the plastic BIC, can only be issued to the applicant/recipient and the other individuals in the case.

Question 14: Does the form authorize the AR to complete the Statement of Facts or any face-to-face interview without the applicant?

Answer 14: No. Competent individuals must participate in the eligibility determination. CCR, Title 22, Sections 50163, 50157 (d)(2), have never allowed the statement of facts or face-to-face interview to be completed by nonfamily ARs in lieu of the applicant. DHS policy is that ARs for competent individuals cannot act in lieu of the client. Again these provisions are not applicable to incompetent individuals.

Question 15: What powers does the AR have with the usage of this form?

Answer 15: The same powers that ARs have always been permitted. Specifically the AR may:

1. submit requested verifications;
2. accompany the applicant/beneficiary to any face-to-face interview;
3. obtain information from the CWD and DED regarding the status of the application;
4. provide medical records and other information to the CWD and DED for disability evaluation;
5. accompany and assist the applicant/beneficiary in the hearing process; and
6. receive a copy of a specific notice of action from the CWD at the request of the applicant/beneficiary.

The applicant/beneficiary still has the responsibility to ensure that all requested verifications are submitted to the CWD or DED, to complete and sign the statement of facts and other Medi-Cal forms, and to attend and participate in all face-to-face interviews.

The applicant/beneficiary has the right to revoke his AR designation at any time by notifying the EW and may designate another individual to assume the role.

Question 16: What if the applicant/beneficiary wants the AR to provide additional legal services or gather additional information from third parties on his/her behalf that do not have anything to do with the eligibility process?

Answer 16: For Medi-Cal program purposes only those functions mentioned in Question 14 are permitted. The **Appointment of Representative** form is only an authorization for the AR to perform those functions, it has no other authority or purpose. Any other service that the applicant/beneficiary wants the AR to perform, such as obtaining information from third parties, must be arranged separately between the applicant/beneficiary, the AR, and the third party.

Question 17: Why does the form include those things that the AR is able to perform? Shouldn't it simply address the responsibilities that the AR has?

Answer 17: This form is a reaffirmation of state regulation. It is important that the form clearly establish Medi-Cal policy concerning the AR. It can be viewed as the DHS' statement of AR Rights and Responsibilities. It would serve no one's interest to eliminate the rights of the AR from the form. The form states all pertinent rights and responsibilities that the applicant/beneficiary has as well as the AR and the county.

Question 18: This form enables the AR to obtain information from and to submit medical records and other information to the Disability Evaluation Division (DED). Does this authority compromise the confidentiality of the client?

Answer 18: No. The DED requested that the references to DED be added to the form. The applicant/beneficiary is authorizing these activities to be performed if the applicant/beneficiary wishes. The items specified on the form are not to be construed as automatic functions without the applicants/beneficiary's prior knowledge of that activity. These authorizations are simply a reiteration of conduct permitted by regulation.

FORM USAGE

Question 19: Does the case or Social Security number (SSN) have to be completed on the form?

Answer 19: No. The case number or SSN line on the form is to allow easier case identification for the county. Both the case and SSN are optional for this form.

Question 20: What if the applicant is an undocumented alien?

Answer 20: If the applicant/beneficiary is undocumented and applying for restricted benefits, then they do not enter a SSN.

Question 21: How does the client revoke the AR designation?

Answer 21: The client may revoke the AR at any time, either orally or in writing. If the revocation is verbal, the county should obtain a written confirmation within a reasonable period of time. If a revocation is received verbally and the county has not yet received a written confirmation of the revocation, the EW should notate in the "County Use Only" section that it has been revoked, the date of the revocation along with the name, address, and phone number of the person requesting the revocation. The EW should also write his/her name and phone number after the above notations have been made. The EW must also make a narrative comment in the case when changes in the AR occur. Should an AR designation be revoked the CWD must not permit an exchange of information to continue with the former AR.

Question 22: How is the form to be completed?

Answer 22: While the form does not have to be completed in the presence of the EW, it is important that the EW review the form with the applicant/beneficiary. The applicant/beneficiary completes Section I which designates the individual appointed as the AR. If the AR is an organization, law firm, or group, the individual chosen to receive/submit information on behalf of the applicant/beneficiary and the AR organization, law firm, or group is entered on the same line that the organization is named. Section I states the actions permitted by the AR, reiterates the responsibilities of the applicant/beneficiary and also states the rights that the applicant/beneficiary has in regard to the appointment and revocation of the AR.

The applicant/beneficiary must sign and date the bottom of Section I. If employed by a business that is acting as the AR, the individual must also complete the "Employed By" section on the signature line.

The AR signs and dates Section II which is a review of the applicants/beneficiaries revocation rights, the authorization period of duration, restrictions on the AR in regard to transfer of appointment and a certification that the AR is of good character.

Three copies of the form will be needed. The applicant/beneficiary and the designated representative must each receive a copy of the completed form and one must remain in the case record.

Question 23: Where should the form be filed in the case record?

Answer 23: DHS prefers that the form be placed on top of the statement of facts so that the EW will know at a glance who the current AR is and how to get in touch with him/her. However, DHS knows that the actual structure of the case record will vary throughout the State. As long as a specific location is chosen for easy reference, the CWD is permitted to decide where that location will be. AR forms that have been revoked should be kept in the case file as a paper trail.

Any questions or comments concerning the **Appointment of Representative** form or the authorized representative subject should be directed to Gary Varner of my staff at (916) 654-5321.

Sincerely,

ORIGINAL SIGNED BY,

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

RE:

Case Name

Case Number

Worker Number

RESPONSIBILITIES OF PUBLIC GUARDIANS/CONSERVATORS OR APPLICANT/BENEFICIARY REPRESENTATIVES

I have accepted the responsibility to act on behalf of _____.
The law and regulation require you to report to the county welfare department any changes in the circumstances of the applicant/beneficiary within ten calendar days following the date the change occurred. You must also operate fully on behalf of the beneficiary in any review that may be required for quality control purposes.

Changes which must be reported within ten days include, but are not limited to:

A change in the beneficiary's property, including community property.

A change in the beneficiary's income.

Entitlement to Veteran's Benefits or an increase in Veteran's Benefits.

Changes in health insurance coverage including enrollment in available health insurance or the discontinuance of health insurance.

A change in the beneficiary's living arrangement, household members, or residence.

The death of the applicant/beneficiary.

A change in guardianship/conservator or representative status.

Any other change in circumstances which may affect eligibility or share of cost.

You are also required (pursuant to Probate Code, Section 700.1, and Welfare and Institutions Code, Section 14009.5) to report the death of the beneficiary within 90 days of the date of death to:

Department of Health Services
Recovery Section
P.O. Box 2471
Sacramento, CA 95812-2471

Refer to "IMPORTANT INFORMATION FOR PERSONS REQUESTING MEDICAL" (MC 219) for a more complete list of your reporting responsibilities.

I hereby state, under penalty of perjury, that the information on this form has been reviewed by me and that I fully understand my responsibilities as the guardian, conservator or representative of

Name of Beneficiary

Name of Guardian/Conservator or Representative

Date

Address of Guardian/Conservator or Representative

Telephone Number of Guardian/Conservator or Representative

White—Case Copy

Yellow—Guardian/Conservator or Representative Copy

APPOINTMENT OF REPRESENTATIVE

SECTION I. TO BE COMPLETED BY APPLICANT/BENEFICIARY

Name	Case or Social Security Number (optional)	Date
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I appoint this individual

Name of Individual

Name of Organization

Complete Address

Telephone Number

as my authorized representative to accompany, assist, and represent me in my application for, or redetermination of, Medi-Cal benefits.

THIS AUTHORIZATION ENABLES THE ABOVE NAMED INDIVIDUAL TO:

- submit requested verifications to the county welfare department;
- accompany me to any required face-to-face interview(s);
- obtain information from the county welfare department and from the State Department of Social Services, Disability Evaluation Division, regarding the status of my application;
- provide medical records and other information regarding my medical problems and limitations to the county welfare department or the State Department of Social Services, Disability Evaluation Division;
- accompany and assist me in the fair hearing process; and
- receive one copy of a specific notice of action from the county welfare department, at the request of the applicant/beneficiary.

I UNDERSTAND THAT I HAVE THE RESPONSIBILITY TO:

- complete and sign the Statement of Facts;
- attend and participate in any required face-to-face interview(s);
- sign MC 220 (Authorization for Release of Medical Information);
- provide all requested verifications before my Medi-Cal eligibility can be determined; and
- accept any consequences of the authorized representative's actions as I would my own.

I UNDERSTAND THAT I HAVE THE RIGHT TO:

- choose anyone that I wish to be my authorized representative;
- revoke this appointment at any time by notifying my Eligibility Worker; and
- request a fair hearing at any time if I am not satisfied with an action taken by the county welfare department.

Applicant/Beneficiary's Signature

Date

Address

SECTION II. TO BE COMPLETED BY THE AUTHORIZED REPRESENTATIVE NAMED. LAW FIRMS, ORGANIZATIONS, AND GROUPS MAY REPRESENT THE APPLICANT/BENEFICIARY BUT AN INDIVIDUAL MUST BE DESIGNATED AS THE CONTACT PERSON TO ACT ON THE APPLICANTS/BENEFICIARIES BEHALF.

I HEREBY ACCEPT THE ABOVE APPOINTMENT AND UNDERSTAND THAT:

- the applicant/beneficiary may revoke this authorization at any time and appoint another individual(s) to act as his/her authorized representative;
- I have no other power to act on behalf of the applicant/recipient, except as stated above;
- I may not act in lieu of the applicant/beneficiary; and
- I may not transfer or reassign my appointment without a new Appointment of Representative form being completed by the applicant/recipient.

I CERTIFY THAT:

- I have not been suspended or prohibited from practice before the Social Security Administration
- I am not, as a current or former officer or employee of the United States, disqualified from acting as the applicant's representative; and
- I am known to be of good character.

This authorization expires upon a final eligibility determination and/or after the right to appeal has expired or at the conclusion of the fair hearing process.

Authorized Representative's Signature	Employed By	Date	Telephone Number
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Required Form -- No Substitute Permitted

COUNTY USE ONLY

Date Verbal Request to Revoke Received

Date Written Request to Revoke Received

Request Received From:

EW Name:

Telephone Number

REF:

Nombre del Caso
Número del Caso
Número del Trabajador(a)

RESPONSABILIDADES DE LOS TUTORES LEGALES/CURADORES LEGALES PUBLICOS O REPRESENTANTES DEL SOLICITANTE/BENEFICIARIO

Usted ha aceptado la responsabilidad de actuar en nombre de _____ y ordenamientos estatales le exigen que informe al departamento de bienestar del condado cualesquier cambios en las circunstancias del solicitante/beneficiario, en un plazo de 10 días corridos, después de la fecha en que ocurrió el cambio. Además, usted debe cooperar completamente, en nombre del beneficiario, en cualquier revisión que se pudiera requerir para propósitos de control de calidad.

Los cambios que se tienen que reportar en un plazo de diez días incluyen, pero no se limitan a:

Un cambio en los bienes del beneficiario, incluyendo comunidad de bienes.

Un cambio en los ingresos del beneficiario.

Derecho a Beneficios para Veteranos o un aumento en Beneficios para Veteranos.

Cambios en cobertura de seguro de salud, incluyendo inscripción en un seguro de salud que haya a la disposición o la discontinuación de seguro de salud.

Un cambio en los arreglos de vivienda, los miembros del hogar o residencia del beneficiario.

La muerte del solicitante/beneficiario.

cambio en tutela (*guardianship*)/condición como curador legal (*conservator*) o representante.

Cualquier otro cambio en circunstancias que pudieran afectar la elegibilidad o parte del costo.

Además, a usted se le exige (en conformidad con la sección 700.1 del Código Testamentario y la sección 14009.5 del Código de Bienestar e Instituciones) reportar la muerte del beneficiario, en un plazo de 90 días a partir de la fecha de la muerte, a:

Department of Health Services
Recovery Section
P.O. Box 2471
Sacramento, CA 95812-2471

Véase a "INFORMACION IMPORTANTE PARA PERSONAS QUE SOLICITAN MEDI-CAL" (MC 219) donde encontrará una lista completa de las responsabilidades que usted tiene de informar.

Por este medio declaro, so pena de perjurio, que he revisado la información en esta forma y que entiendo completamente mis responsabilidades como tutor legal, curador legal o representante de

Nombre del Beneficiario

Tutor Legal/Curador Legal o Representante	Fecha
Sección del Tutor Legal/Curador Legal o Representante	No. de Teléfono del Tutor Legal/Curador Legal o Representante

White-Case Copy Yellow-Guardian/Conservator or Representative Copy

NOMBRAMIENTO DEL REPRESENTANTE

SECCION I. PARA LLENARSE POR EL SOLICITANTE/BENEFICIARIO

Nombre	No. del Caso o del Seguro Social (opcional)	Fecha
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Nombre a esta persona _____ / _____
Nombre de la persona *Nombre de la Organización*

Dirección Completa

Número de Teléfono

como mi representante autorizado para acompañarme, ayudarme y representarme en mi solicitud o nueva determinación para beneficios de Medi-Cal.

ESTA AUTORIZACION PERMITE A LA PERSONA MENCIONADA:

- presentar al departamento de bienestar del condado, las verificaciones que se han solicitado;
- acompañarme a cualquier entrevista en la que se requiera que me presente en persona;
- obtener información del departamento de bienestar del condado y de la División de Evaluación de Incapacidad del Departamento Estatal de Servicios Sociales, referente a la condición de mi solicitud;
- proporcionar registros médicos y otra información referente a mis problemas y limitaciones médicas al departamento de bienestar del condado o a la División de Evaluación de Incapacidad del Departamento Estatal de Servicios Sociales;
- acompañarme y ayudarme en el proceso de audiencia imparcial; y
- recibir una copia de una notificación de acción específica del departamento de bienestar del condado, cuando lo solicite el solicitante/beneficiario.

ENTIENDO QUE TENGO LA RESPONSABILIDAD DE:

- llenar y firmar la Declaración de Datos;
- asistir y participar en cualquier entrevista que se requiera en persona;
- firmar la forma MC 220 (Autorización para Divulgar Información Médica);
- proporcionar todas las verificaciones solicitadas antes de que se pueda determinar si reúno los requisitos para recibir Medi-Cal; y
- aceptar cualquier consecuencia de las acciones del representante autorizado como si fueran las mías propias.

ENTIENDO QUE TENGO EL DERECHO A:

- escoger a cualquier persona que yo desee para que sea mi representante autorizado;
- revocar este nombramiento en cualquier momento, notificando a mi Trabajador(a) de Elegibilidad; y
- solicitar una audiencia imparcial en cualquier momento si no estoy satisfecho con alguna acción que tome el departamento de bienestar del condado.

Firma del Solicitante/Beneficiario

Fecha

Dirección



SECCION II. PARA COMPLETARSE POR EL REPRESENTANTE AUTORIZADO DESIGNADO. *LOS BUFETES DE ABOGADOS, ORGANIZACIONES Y GRUPOS LEGALES PUEDEN REPRESENTAR AL SOLICITANTE/BENEFICIARIO, PERO SE TIENE QUE DESIGNAR A UNA PERSONA COMO EL CONTACTO PARA ACTUAR EN NOMBRE DE LOS SOLICITANTES/BENEFICIARIOS.*

POR ESTE MEDIO ACEPTO EL NOMBRAMIENTO ANTERIOR Y ENTIENDO QUE:

- el solicitante/beneficiario puede revocar esta autorización en cualquier momento y nombrar a otra(s) persona(s) para actuar como su representante autorizado;
- no tengo otro poder para actuar en nombre del solicitante/beneficiario, excepto como se establece anteriormente;
- no puedo actuar en lugar del solicitante/beneficiario; y
- no puedo transferir o volver a asignar mi nombramiento sin que el solicitante/beneficiario haya llenado una nueva forma de Nombramiento de Representante.

CERTIFICO QUE:

- no he sido suspendido ni se me ha prohibido ejercer ante la Administración del Seguro Social;
- no estoy, como oficial o empleado de los Estados Unidos en la actualidad o en el pasado, desautorizado para actuar como el representante del solicitante; y
- se me conoce como persona de buena reputación.

Esta autorización se vence una vez que se haya establecido una determinación de elegibilidad final y/o después de que se haya vencido el derecho a apelar o cuando se concluya el proceso de audiencia imparcial.

Firma del Representante Autorizado	Empleado Por	Fecha	Número de Teléfono
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Forma Obligatoria—No se Permiten Substitutos

SOLO PARA USO DEL CONDADO

Date Verbal Request to Revoke Received Date Written Request to Revoke Received Request Received From:

EW Name: _____ Telephone Number _____